February 20, 2004

ENGROSSED
SENATE BILL No. 428

DIGEST OF SB 428 (Updated February 18, 2004 3:35 pm - DI 77)

Citations Affected: IC 5-15; IC 12-15; IC 16-21; IC 16-39.

Synopsis: Hospital matters. Provides that records of certain hospitals are not public records. Authorizes the office of Medicaid policy and planning (office) to implement alternative payment methodologies for payable claim payments to a hospital if the office determines that the federal Centers for Medicare and Medicaid Services will not approve the submitted payment methodology. Allows the state department of health (state department) to disclose inpatient and outpatient discharge information to hospitals that have submitted the information. Allows a hospital trade association to disclose health record information received by the association from a provider to the state department to be used for data aggregation. Changes a retrieval charge to a labor charge for providing copies of medical records.

Effective: July 1, 2003 (retroactive); July 1, 2004.

Miller
(HOUSE SPONSORS — BROWN C, BECKER)

January 12, 2004, read first time and referred to Committee on Health and Provider Services.
January 22, 2004, amended, reported favorably — Do Pass.
January 26, 2004, read second time, ordered engrossed. Engrossed.
January 29, 2004, read third time, passed. Yeas 47, nays 0.

HOUSE ACTION
February 4, 2004, read first time and referred to Committee on Public Health.
February 19, 2004, amended, reported — Do Pass.

February 20, 2004

Second Regular Session 113th General Assembly (2004)

PRINTING CODE. Amendments: Whenever an existing statute (or a section of the Indiana Constitution) is being amended, the text of the existing provision will appear in this style type, additions will appear in **this style type**, and deletions will appear in ~~this style type.~~

Additions: Whenever a new statutory provision is being enacted (or a new constitutional provision adopted), the text of the new provision will appear in **this style type**. Also, the word **NEW** will appear in that style type in the introductory clause of each SECTION that adds a new provision to the Indiana Code or the Indiana Constitution.

Conflict reconciliation: Text in a statute in *this style type* or ~~*this style type*~~ reconciles conflicts between statutes enacted by the 2003 Regular Session of the General Assembly.

ENGROSSED
SENATE BILL No. 428

A BILL FOR AN ACT to amend the Indiana Code concerning health.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. IC 5-15-6-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 11. This chapter does not apply to public records of a ~~county~~ hospital ~~described~~ ~~in~~ **established and operated under** IC 16-22 ~~and~~ **or** IC 16-23.

SECTION 2. IC 12-15-15-1.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 1.6. (a) This section applies only if the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (A), (B), or (C) of this chapter.**

(b) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (A) of this chapter, the office may make payments alternative to the payments under section 1.5(b) STEP FIVE (A) of this chapter if:

(1) the payments for a state fiscal year are made only to the hospitals that would have been eligible for payments for that

state fiscal year under section 1.5(b) STEP FIVE (A) of this chapter; and

(2) the payment for a state fiscal year to each hospital is an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (A) of this chapter for that state fiscal year.

(c) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (B) of this chapter, the office may make payments alternative to the payments under section 1.5(b) STEP FIVE (B) of this chapter if:

(1) the payments for a state fiscal year are made only to the hospitals that would have been eligible for payments for that state fiscal year under section 1.5(b) STEP FIVE (B) of this chapter; and

(2) the payment for a state fiscal year to each hospital is an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (B) of this chapter for that state fiscal year.

(d) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (C) of this chapter, the office may make payments alternative to the payments under section 1.5(b) STEP FIVE (C) of this chapter if:

(1) the payments for a state fiscal year are made only to the hospitals that would have been eligible for payments for that state fiscal year under section 1.5(b) STEP FIVE (C) of this chapter; and

(2) the payment for a state fiscal year to each hospital is an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (C) of this chapter for that state fiscal year.

(e) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under subsection (b), (c), or (d), the office shall use the funds that would have served as the non-federal share of the payments for a state fiscal year to serve as the non-federal share of a payment pool that shall be distributed to hospitals receiving payments under section 9.5 of this chapter for a state fiscal year. The payment pool shall be distributed on a pro rata basis based upon the amount of payment each hospital received under section 9.5 of this chapter for the state fiscal year.

(f) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under subsection (e), the office shall use the funds that would have served as the non-federal share of such payments for a state fiscal year to serve as the non-federal share of a payment program for hospitals to be established by the office. The program shall distribute payments for a state fiscal year based upon a methodology determined by the office to be equitable under the circumstances.

SECTION 3. IC 12-15-15-9, AS AMENDED BY P.L.255-2003, SECTION 19, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 9. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and:

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital licensed under IC 16-21-2 that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5 is entitled to a payment under this section.

(c) ~~For a state fiscal year,~~ **Except as provided under section 9.8 of this chapter and** subject to section 9.6 of this chapter, **for a state fiscal year,** the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP SIX of the following STEPS:

STEP ONE: Identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 during the state fiscal year; and

(B) the county to which each payable claim is attributed.

STEP TWO: For each county identified in STEP ONE, identify:

(A) each hospital that submitted to the division one (1) or more payable claims under IC 12-16-7.5 attributed to the

county during the state fiscal year; and

(B) the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP THREE: For each county identified in STEP ONE, identify the amount of county funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP FOUR: For each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, calculate the hospital's percentage share of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b). Each hospital's percentage share is based on the total amount of the hospital's payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year, calculated as a percentage of the total amount of all hospital payable claims submitted to the division under IC 12-16-7.5 attributed to the county during the state fiscal year.

STEP FIVE: Subject to subsection (j), for each hospital identified in STEP ONE, with respect to each county identified in STEP ONE, multiply the hospital's percentage share calculated under STEP FOUR by the amount of the county's funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b).

STEP SIX: Determine the sum of all amounts calculated under STEP FIVE for each hospital identified in STEP ONE with respect to each county identified in STEP ONE.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of a hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is funded from the funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) of each county to which a payable claim under IC 12-16-7.5 submitted to the division during the state fiscal year by the hospital is attributed.

(f) The amount of a county's transferred funds available to be used to fund the non-federal share of a payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) that the total

amount of the hospital's payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year bears to the total amount of all hospital payable claims under IC 12-16-7.5 attributed to the county submitted to the division during the state fiscal year.

(g) Any county's funds identified in subsection (f) that remain after the non-federal share of a hospital's payment has been funded are available to serve as the non-federal share of a payment to a hospital under section 9.5 of this chapter.

(h) For purposes of this section, "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b)(1).

(i) For purposes of this section:

(1) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(2) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

(j) The amount calculated under STEP FIVE of subsection (c) for a hospital with respect to a county may not exceed the total amount of the hospital's payable claims attributed to the county during the state fiscal year.

SECTION 4. IC 12-15-15-9.5, AS ADDED BY P.L.255-2003, SECTION 20, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 9.5. (a) For purposes of this section and IC 12-16-7.5-4.5, a payable claim is attributed to a county if the payable claim is submitted to the division by a hospital licensed under IC 16-21-2 for payment under IC 12-16-7.5 for care provided by the hospital to an individual who qualifies for the hospital care for the indigent program under IC 12-16-3.5-1 or IC 12-16-3.5-2 and;

(1) who is a resident of the county;

(2) who is not a resident of the county and for whom the onset of the medical condition that necessitated the care occurred in the county; or

(3) whose residence cannot be determined by the division and for whom the onset of the medical condition that necessitated the care occurred in the county.

(b) For each state fiscal year ending after June 30, 2003, a hospital

licensed under IC 16-21-2:

(1) that submits to the division during the state fiscal year a payable claim under IC 12-16-7.5; and

(2) whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year;

is entitled to a payment under this section.

(c) ~~For a state fiscal year,~~ **Except as provided in section 9.8 of this chapter and** subject to section 9.6 of this chapter, **for a state fiscal year,** the office shall pay to a hospital referred to in subsection (b) an amount equal to the amount, based on information obtained from the division and the calculations and allocations made under IC 12-16-7.5-4.5, that the office determines for the hospital under STEP EIGHT of the following STEPS:

STEP ONE: Identify each county whose transfer of funds to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) for the state fiscal year was less than the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP TWO: For each county identified in STEP ONE, calculate the difference between the amount of funds of the county transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and the total amount of all hospital payable claims attributed to the county and submitted to the division during the state fiscal year.

STEP THREE: Calculate the sum of the amounts calculated for the counties under STEP TWO.

STEP FOUR: Identify each hospital whose payment under section 9(c) of this chapter was less than the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP FIVE: Calculate for each hospital identified in STEP FOUR the difference between the hospital's payment under section 9(c) of this chapter and the total amount of the hospital's payable claims under IC 12-16-7.5 submitted by the hospital to the division during the state fiscal year.

STEP SIX: Calculate the sum of the amounts calculated for each of the hospitals under STEP FIVE.

STEP SEVEN: For each hospital identified in STEP FOUR, calculate the hospital's percentage share of the amount calculated under STEP SIX. Each hospital's percentage share is based on the

amount calculated for the hospital under STEP FIVE calculated as a percentage of the sum calculated under STEP SIX.

STEP EIGHT: For each hospital identified in STEP FOUR, multiply the hospital's percentage share calculated under STEP SEVEN by the sum calculated under STEP THREE. The amount calculated under this STEP for a hospital may not exceed the amount by which the hospital's total payable claims under IC 12-16-7.5 submitted during the state fiscal year exceeded the amount of the hospital's payment under section 9(c) of this chapter.

(d) A hospital's payment under subsection (c) is in the form of a Medicaid add-on payment. The amount of the hospital's add-on payment is subject to the availability of funding for the non-federal share of the payment under subsection (e). The office shall make the payments under subsection (c) before December 15 that next succeeds the end of the state fiscal year.

(e) The non-federal share of a payment to a hospital under subsection (c) is derived from funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) and not expended under section 9 of this chapter. To the extent possible, the funds shall be derived on a proportional basis from the funds transferred by each county identified in subsection (c), STEP ONE:

(1) to which at least one (1) payable claim submitted by the hospital to the division during the state fiscal year is attributed; and

(2) whose funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) were not completely expended under section 9 of this chapter.

The amount available to be derived from the remaining funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) to serve as the non-federal share of the payment to a hospital under subsection (c) is an amount that bears the same proportion to the total amount of funds transferred by all the counties identified in subsection (c), STEP ONE, that the amount calculated for the hospital under subsection (c), STEP FIVE, bears to the amount calculated under subsection (c), STEP SIX.

(f) Except as provided in subsection (g), the office may not make a payment under this section until the payments due under section 9 of this chapter for the state fiscal year have been made.

(g) If a hospital appeals a decision by the office regarding the hospital's payment under section 9 of this chapter, the office may make payments under this section before all payments due under section 9 of

this chapter are made if:

(1) a delay in one (1) or more payments under section 9 of this chapter resulted from the appeal; and

(2) the office determines that making payments under this section while the appeal is pending will not unreasonably affect the interests of hospitals eligible for a payment under this section.

(h) Any funds transferred to the Medicaid indigent care trust fund under STEP FOUR of IC 12-16-7.5-4.5(b) remaining after payments are made under this section shall be used as provided in IC 12-15-20-2(8)(D).

(i) For purposes of this section:

(1) "payable claim" has the meaning set forth in IC 12-16-7.5-2.5(b);

(2) the amount of a payable claim is an amount equal to the amount the hospital would have received under the state's fee-for-service Medicaid reimbursement principles for the hospital care for which the payable claim is submitted under IC 12-16-7.5 if the individual receiving the hospital care had been a Medicaid enrollee; and

(3) a payable hospital claim under IC 12-16-7.5 includes a payable claim under IC 12-16-7.5 for the hospital's care submitted by an individual or entity other than the hospital, to the extent permitted under the hospital care for the indigent program.

SECTION 5. IC 12-15-15-9.8 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 9.8. (a) This section applies only if the office determines, based on information received from the United States Centers for Medicare and Medicaid Services, that a state Medicaid plan amendment implementing the payment methodology in:**

(1) section 9(c) of this chapter; or

(2) section 9.5(c) of this chapter;

will not be approved by the Centers for Medicare and Medicaid Services.

(b) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9(c) of this chapter. A

payment methodology implemented under this subsection is in place of the payment methodology under section 9(c) of this chapter.

(c) The office may amend the state Medicaid plan to implement an alternative payment methodology to the payment methodology under section 9.5 of this chapter. The alternative payment methodology must provide each hospital that would have received a payment under section 9.5(c) of this chapter during a state fiscal year with an amount for the state fiscal year that is as equal as possible to the amount each hospital would have received under the payment methodology under section 9.5(c) of this chapter. A payment methodology implemented under this subsection is in place of the payment methodology under section 9.5(c) of this chapter.

SECTION 6. IC 16-21-6-7, AS AMENDED BY P.L.44-2002, SECTION 4, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 7. (a) The reports filed under section 3 of this chapter:

(1) may not contain information that personally identifies a patient or a consumer of health services; and

(2) must be open to public inspection.

(b) The state department shall provide copies of the reports filed under section 3 of this chapter to the public upon request, at the state department's actual cost.

(c) The following apply to information that is filed under section 6 of this chapter:

(1) Information filed with the state department's designated contractor:

(A) is confidential; and

(B) must be transferred by the contractor to the state department in a format determined by the state department.

(2) Information filed with the state department or transferred to the state department by the state department's designated contractor is not confidential, except that information that:

(A) personally identifies; or

(B) may be used to personally identify;

a patient or consumer may not be disclosed **to a third party other than to a hospital that has filed inpatient and outpatient discharge information.**

(d) An analysis completed by the state department of information that is filed under section 6 of this chapter:

(1) may not contain information that personally identifies or may

be used to personally identify a patient or consumer of health services, unless the information is determined by the state department to be necessary for a public health activity;

(2) must be open to public inspection; and

(3) must be provided to the public by the state department upon request at the state department's actual cost.

SECTION 7. IC 16-39-5-3, AS AMENDED BY P.L.44-2002, SECTION 5, IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 3. (a) As used in this section,"association" refers to an Indiana hospital trade association founded in 1921.

(b) As used in this section, "data aggregation" means a combination of information obtained from the health records of a provider with information obtained from the health records of one (1) or more other providers to permit data analysis that relates to the health care operations of the providers.

(c) Except as provided in IC 16-39-4-5, the original health record of the patient is the property of the provider and as such may be used by the provider without specific written authorization for legitimate business purposes, including the following:

(1) Submission of claims for payment from third parties.

(2) Collection of accounts.

(3) Litigation defense.

(4) Quality assurance.

(5) Peer review.

(6) Scientific, statistical, and educational purposes.

(d) In use under subsection (c), the provider shall at all times protect the confidentiality of the health record and may disclose the identity of the patient only when disclosure is essential to the provider's business use or to quality assurance and peer review.

(e) A provider may disclose a health record to another provider or to a nonprofit medical research organization to be used in connection with a joint scientific, statistical, or educational project. Each party that receives information from a health record in connection with the joint project shall protect the confidentiality of the health record and may not disclose the patient's identity except as allowed under this article.

(f) A provider may disclose a health record or information obtained from a health record to the association for use in connection with a ~~voluntary~~ data aggregation project undertaken by the association. However, the provider may disclose the identity of a patient to the association only when the disclosure is essential to the project. The association may disclose the information it receives from a provider

under this subsection to the state department to be used in connection with a ~~voluntary~~ public health activity **or data aggregation of inpatient and outpatient discharge information submitted under IC 16-21-6-6.** The information disclosed by:

(1) a provider to the association; or

(2) the association to the state department;

under this subsection is confidential.

(g) Information contained in final results obtained by the state department for a ~~voluntary~~ public health activity that:

(1) is based on information disclosed under subsection (f); and

(2) identifies or could be used to determine the identity of a patient;

is confidential. All other information contained in the final results is not confidential.

(h) Information that is:

(1) advisory or deliberative material of a speculative nature; or

(2) an expression of opinion;

including preliminary reports produced in connection with a ~~voluntary~~ public health activity using information disclosed under subsection (f), is confidential and may only be disclosed by the state department to the association and to the provider who disclosed the information to the association.

(i) The association shall, upon the request of a provider that contracts with the association to perform data aggregation, make available information contained in the final results of data aggregation activities performed by the association **in compliance with subsection (f).**

(j) A person who recklessly violates or fails to comply with subsections (e) through (h) commits a Class C infraction. Each day a violation continues constitutes a separate offense.

(k) This chapter does not do any of the following:

(1) Repeal, modify, or amend any statute requiring or authorizing the disclosure of information about any person.

(2) Prevent disclosure or confirmation of information about patients involved in incidents that are reported or required to be reported to governmental agencies and not required to be kept confidential by the governmental agencies.

SECTION 8. IC 16-39-9-3 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: Sec. 3. (a) A provider may collect a charge of twenty-five cents ($0.25) per page for making and providing copies of medical records. If the provider collects a ~~retrieval~~ **labor** charge under subsection (b), the

provider may not charge for making and providing copies of the first ten (10) pages of a medical record under this subsection.

(b) A provider may collect a fifteen dollar ($15) ~~retrieval~~ **labor** charge in addition to the per page charge collected under subsection (a).

(c) A provider may collect actual postage costs in addition to the charges collected under subsections (a) and (b).

(d) If the person requesting the copies requests that the copies be provided within two (2) working days, and the provider provides the copies within two (2) working days, the provider may collect a fee of ten dollars ($10) in addition to the charges collected under subsections (a) through (c).

SECTION 9. **An emergency is declared for this act.**

COMMITTEE REPORT

Madam President: The Senate Committee on Health and Provider Services, to which was referred Senate Bill No. 428, has had the same under consideration and begs leave to report the same back to the Senate with the recommendation that said bill be AMENDED as follows:

Page 9, line 13, strike "voluntary".

and when so amended that said bill do pass.

(Reference is to SB 428 as introduced.)

MILLER, Chairperson

Committee Vote: Yeas 10, Nays 0.

COMMITTEE REPORT

Mr. Speaker: Your Committee on Public Health, to which was referred Senate Bill 428, has had the same under consideration and begs leave to report the same back to the House with the recommendation that said bill be amended as follows:

Replace the effective dates in SECTIONS 1 through 6 with "[EFFECTIVE JULY 1, 2003 (RETROACTIVE)]:".

Page 1, between the enacting clause and line 1, begin a new paragraph and insert:

"SECTION 1. IC 5-15-6-11 IS AMENDED TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2004]: Sec. 11. This chapter does not apply to public records of a ~~county~~ hospital ~~described~~ ~~in~~ **established and operated under** IC 16-22 ~~and~~ **or** IC 16-23.

SECTION 2. IC 12-15-15-1.6 IS ADDED TO THE INDIANA CODE AS A **NEW** SECTION TO READ AS FOLLOWS [EFFECTIVE JULY 1, 2003 (RETROACTIVE)]: **Sec. 1.6. (a) This section applies only if the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (A), (B), or (C) of this chapter.**

(b) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (A) of this chapter, the office may make payments alternative to the payments under section 1.5(b) STEP FIVE (A) of this chapter if:

(1) the payments for a state fiscal year are made only to the hospitals that would have been eligible for payments for that state fiscal year under section 1.5(b) STEP FIVE (A) of this chapter; and

(2) the payment for a state fiscal year to each hospital is an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (A) of this chapter for that state fiscal year.

(c) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (B) of this chapter, the office may make payments alternative to the payments under section 1.5(b) STEP FIVE (B) of this chapter if:

(1) the payments for a state fiscal year are made only to the hospitals that would have been eligible for payments for that state fiscal year under section 1.5(b) STEP FIVE (B) of this chapter; and

(2) the payment for a state fiscal year to each hospital is an

amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (B) of this chapter for that state fiscal year.

(d) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under section 1.5(b) STEP FIVE (C) of this chapter, the office may make payments alternative to the payments under section 1.5(b) STEP FIVE (C) of this chapter if:

(1) the payments for a state fiscal year are made only to the hospitals that would have been eligible for payments for that state fiscal year under section 1.5(b) STEP FIVE (C) of this chapter; and

(2) the payment for a state fiscal year to each hospital is an amount that is as equal as possible to the amount each hospital would have received under section 1.5(b) STEP FIVE (C) of this chapter for that state fiscal year.

(e) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under subsection (b), (c), or (d), the office shall use the funds that would have served as the non-federal share of the payments for a state fiscal year to serve as the non-federal share of a payment pool that shall be distributed to hospitals receiving payments under section 9.5 of this chapter for a state fiscal year. The payment pool shall be distributed on a pro rata basis based upon the amount of payment each hospital received under section 9.5 of this chapter for the state fiscal year.

(f) If the United States Centers for Medicare and Medicaid Services determines not to approve payments under subsection (e), the office shall use the funds that would have served as the non-federal share of such payments for a state fiscal year to serve as the non-federal share of a payment program for hospitals to be established by the office. The program shall distribute payments for a state fiscal year based upon a methodology determined by the office to be equitable under the circumstances.".

Page 10, after line 28, begin a new paragrah and insert:

"SECTION 9. **An emergency is declared for this act.**".
Renumber all SECTIONS consecutively.

and when so amended that said bill do pass.

(Reference is to SB 428 as printed January 23, 2004.)

BROWN C, Chair

Committee Vote: yeas 11, nays 0.